

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034727

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 145 Primary Registration District No. 1002 Registrar's No. 4966

STATE FILE NUMBER

FILED OCT 15 1962

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Town Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>4 years</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Alexis Home</u>		d. STREET ADDRESS (If outside, give location) <u>5331 Highland</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Christopher</u> Middle <u>Farnan</u> Last <u>Farnan</u>		4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-3-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired janitor</u>		11. BIRTHPLACE (City and state or country) <u>Clyde, Mo.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>William Farnan</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Donaldson</u>	
14. NAME OF HUSBAND OR WIFE <u>Mrs. Don Bosch 3501 Silver, K. C. Ks.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>broncho pneumonia (hypostatic)</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>epilepsy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>epilepsy</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <u>3-19-58</u> Month, Day, Year <u>9-28-62</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>3-19-58</u> to <u>9-28-62</u> and last saw her/him alive on <u>9-27-62</u>		Death occurred at <u>402 Wirthman Bldg., K.C.9, Mo.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Joseph A. Fogarty M.D.</u>		22b. ADDRESS <u>402 Wirthman Bldg., K.C.9, Mo.</u>	
22c. DATE SIGNED <u>9-29-62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>Oct. 1, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
23d. LOCATION (City, town, or county) (State) <u>Hickman Mills, Mo.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Thomas E. Quirk 4601 Liberty, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>9.29.62</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Joseph A. Fogarty MEDICAL CERTIFICATION

ITEM NO.

DATE AMENDED

VS 300  
Rev. 4/59

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23758

94500

1286.2

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

USE BLACK-INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOL

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

JOSEPH A. FOGARTY  
MEDICAL CERTIFICATION

DOCUMENT

William Farman

Alice Donaldson

NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
No No

16. SOCIAL SECURITY NO.  
493-18-9371

17. INFORMANT  
Address  
Mrs Don Bosch 3501 Silver, K.C.K.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Broncho-pneumonia (Hypertensive)*  
*Arterio Sclerosis*

INTERVAL BETWEEN  
ONSET AND DEATH

*10 days*

*20 yrs.*

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)  
*Epilepsy*

PART III. If deceased was female was  
there a pregnancy in last 90 days.  
☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☐

20a. ACCIDENT ☐

SUICIDE ☐

HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in PART I or PART II of item 18.)  
*none*

20c. TIME OF  
INJURY

Hour  
a.m.  
p.m.

Month, Day, Year

20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from *3/19/58*

and last saw him alive on *7/27/62*

Death occurred at

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

*Burial*

*Oct 1, 1962*

*Mt. Olivet Cemetery*

*Hickman Mills, Mo.*

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

*Thomas E. Quirk 4601 Liberty St.*

*9-29-62*

*Ruth Long*

(Licensed Embalmer's Statement on Reverse Side)

# STATEMENT BY LICENSED EMBALMER

NEW YORK

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

14714  
Tourist